FluWatch

Public Health Agency of Canada | Agence de la santé publique du Canada

November 12 to 18, 2017 (Week 46)

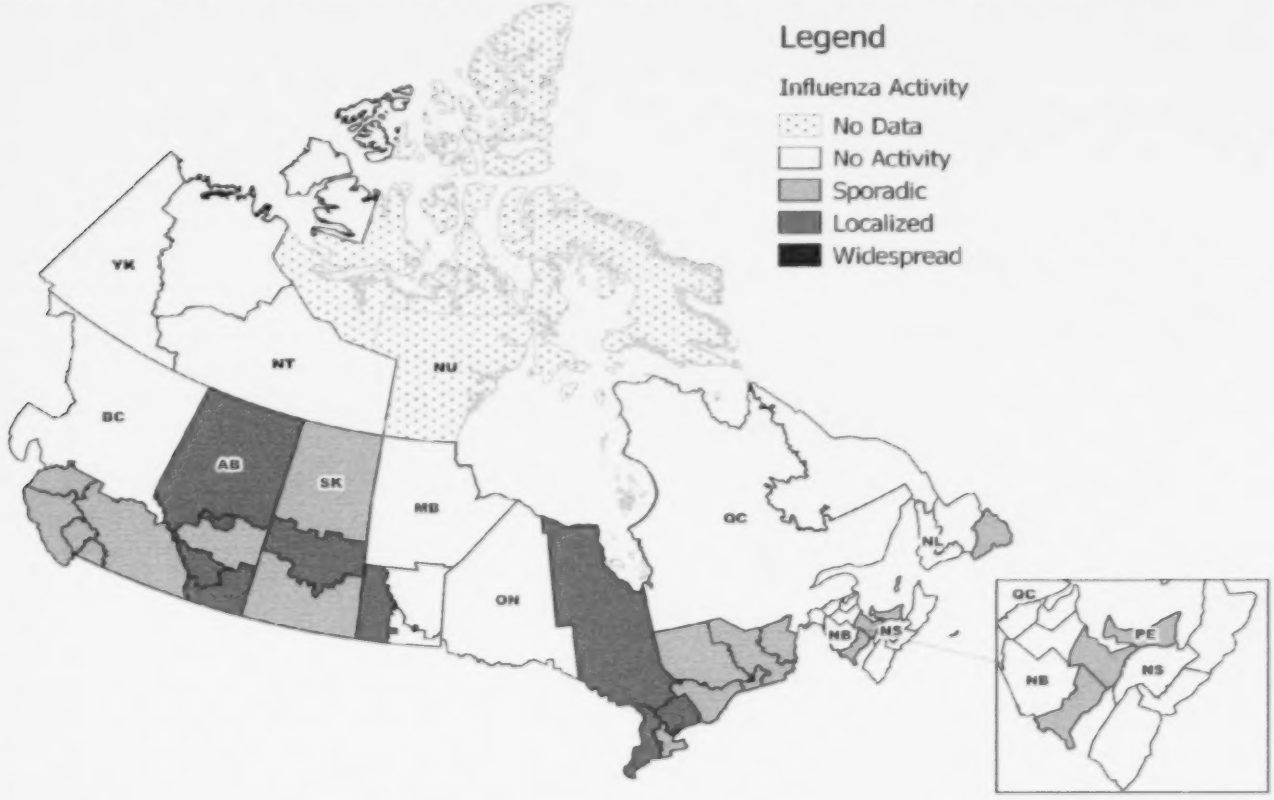
Overall Summary

- At the national level, the influenza season began early this year, crossing the seasonal threshold last week (week 45).
- The number and percentage of laboratory tests positive for both influenza A and B continues to increase, and is higher for this time of year compared to previous seasons.
- The majority of influenza detections continue to be A(H3N2) although an elevated number of influenza B detections has also been reported.
- The number of influenza-related hospitalizations among adults and the proportion of regions reporting localized activity are above the expected levels for this time of year.
- For more information on the flu, see our Flu(influenza) web page.

Influenza/Influenza-like Illness (ILI) Activity (geographic spread)

In week 46, 11 regions in Alberta (4), Saskatchewan (1), Manitoba (2) and Ontario (4) reported localized activity, and 18 regions (British Columbia (4), Alberta (1), Saskatchewan (2), Ontario (2), Quebec (5), New Brunswick (2), Prince Edward Island (1), and Newfoundland and Labrador (1)) reported sporadic activity. Consistent with the increased number of influenza detections this season, a greater number of regions are reporting sporadic activity compared to previous seasons. In week 46, the number of regions reporting localized activity was above expected levels.

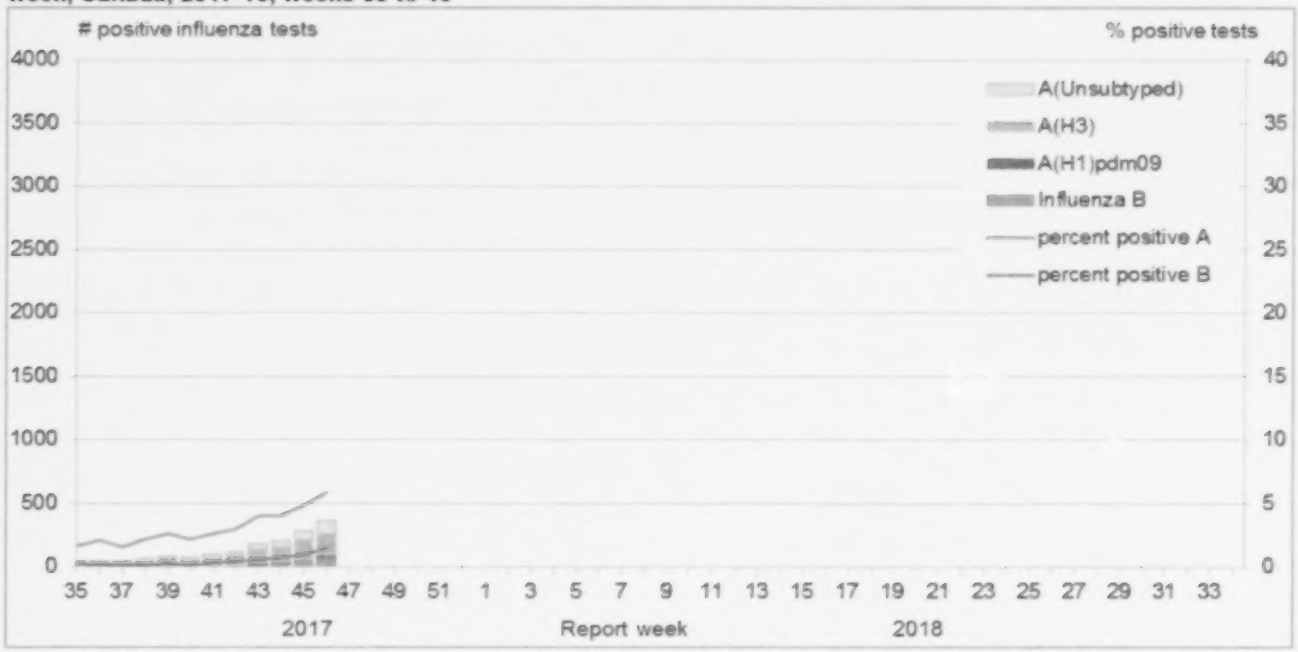
Figure 1 – Map of overall influenza/ILI activity level by province and territory, Canada, 2017-18, Week 46



Laboratory-Confirmed Influenza Detections

The 2017-18 season has begun early, with laboratory detections of influenza entering seasonal levels two weeks earlier than the median of the past seven seasons. In week 46, both influenza A and B detections continued to increase, with 7.3% of tests positive. The number and percentage of both influenza A and B tests positive is higher for this time of year compared to the same period during the previous seven seasons. Influenza B detections are elevated at 1.5% of tests positive in week 46; a level not typically reached until late January. For data on other respiratory virus detections, see the Respiratory Virus Detections in Canada Report.

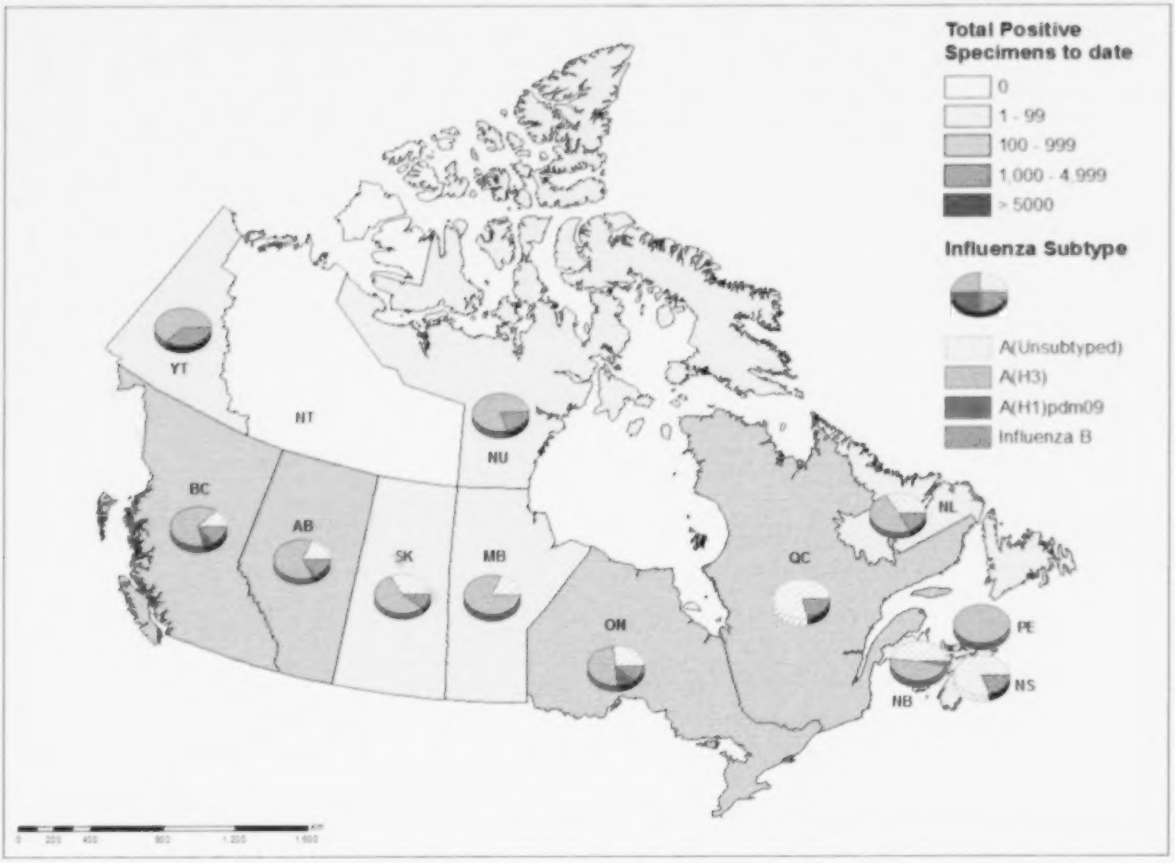
Figure 2 – Number of positive influenza tests and percentage of tests positive, by type, subtype and report week, Canada, 2017-18, weeks 35 to 46



The shaded area indicates weeks where the positivity rate was at least 5% and a minimum of 15 positive tests were observed, signalling the period of seasonal influenza activity.

To date this season, 1545 laboratory-confirmed influenza detections have been reported, of which 85% have been influenza A. Influenza A(H3N2) has been the most common subtype detected this season, representing 94% of subtyped influenza A detections. For more detailed weekly and cumulative influenza data, see the text descriptions for Figures 2 and 3 or the Respiratory Virus Detections in Canada Report.

Figure 3 – Cumulative numbers of positive influenza specimens by type/subtype and province/territory, Canada, 2017-18, weeks 35 to 46



To date this season, detailed information on age and type/subtype has been received for 1306 laboratory-confirmed influenza cases (Table 1). Among all influenza cases with reported age and type/subtype information, slightly less than half of the cases have been reported in adults 65 years of age and older. This proportion was higher among cases of influenza A (50%) compared to influenza B (33%).

Table 1 – Cumulative numbers of positive influenza specimens by type, subtype and age-group reported through case-based laboratory reporting, Canada, 2017-18, weeks 35 to 46

Age groups (years)	Cumulative (August 27, 2017 to November 18, 2017)						
	Influenza A				B	Influenza A and B	
	A Total	A(H1) pdm09	A(H3)	A (UnS)[3]	Total	#	%
0-4	71	11	41	19	20	91	7%
5-19	102	10	53	39	42	144	11%
20-44	189	6	123	60	31	220	17%
45-64	202	11	124	67	34	236	18%
65+	552	4	439	109	63	615	47%
Total	1116	42	780	294	190	1306	100%

[1]UnS: unsubtyped: The specimen was typed as influenza A, but no result for subtyping was available;

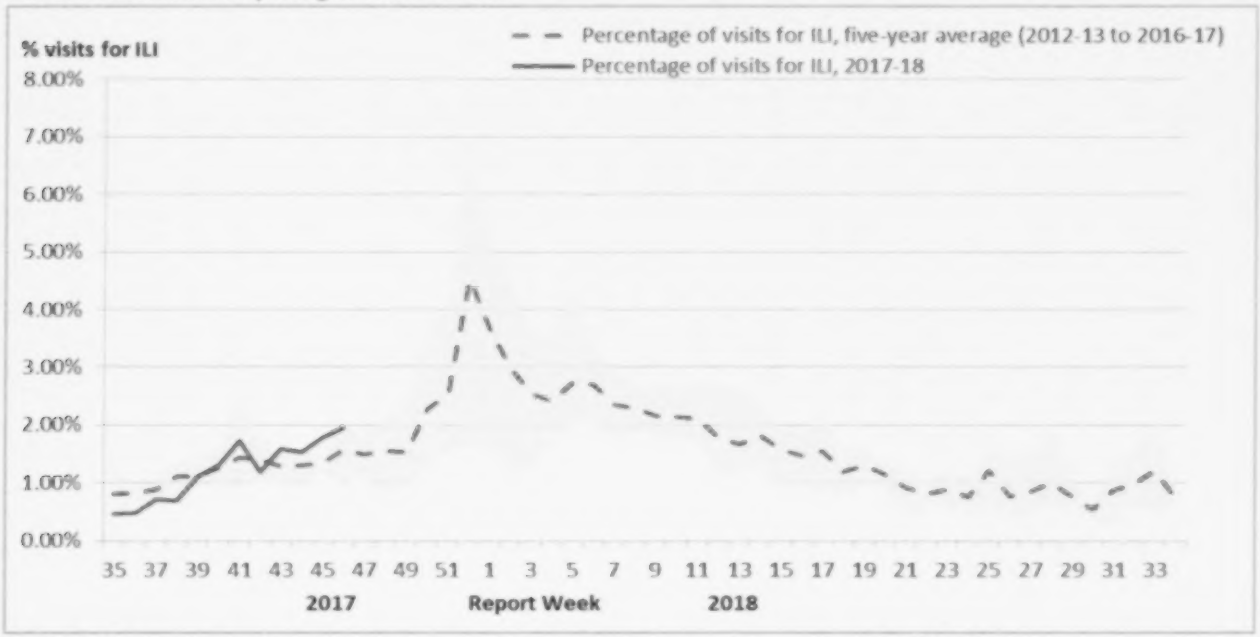
Syndromic / Influenza-like Illness Surveillance

Healthcare Practitioners Sentinel Syndromic Surveillance

In week 46, 1.9% of visits to healthcare professionals were due to influenza-like illness; an increase compared to the previous week, and above the 5-year average.

Figure 4 – Percentage of visits for ILI reported by sentinels by report week, Canada, 2017-18, weeks 35 to 46

Number of Sentinels Reporting in Week 46: 115



The shaded area represents the maximum and minimum percentage of visits for ILI reported by week from seasons 2012-13 to 2016-17

Participatory Syndromic Surveillance

FluWatchers is a participatory ILI surveillance system that relies on weekly voluntary submissions of syndromic information from Canadians across Canada.

In week 46, 1399 participants reported to FluWatchers, of which 2% reported symptoms of cough and fever in the preceding week and 32% of these consulted a healthcare professional. Among participants who reported cough and fever, 74% reported days missed from work or school, resulting in a combined total of 47 missed days.

Table 2 – Summary of influenza-like illness symptoms reported by participating Canadians, Canada, 2017-18, week 46

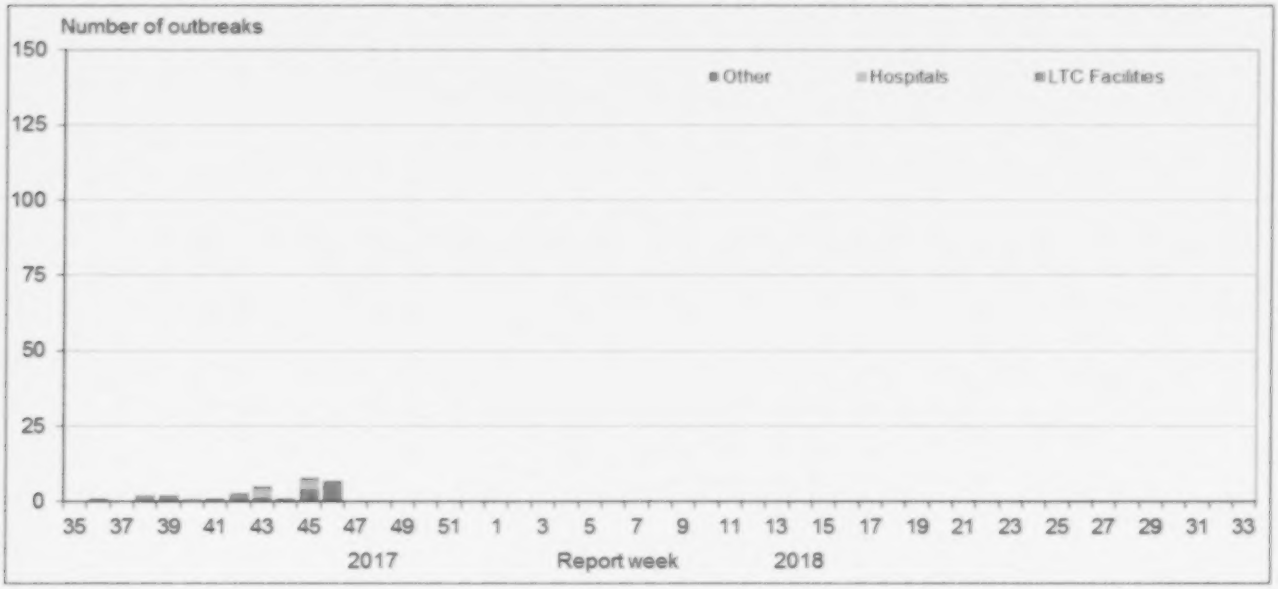
Number of Participants Reporting	Percentage participants reporting Cough and Fever	Percentage of participants with cough and fever who consulted a healthcare professional	Percentage of participants with cough and fever who reported missed days from work or school	Number of missed days from work or school
1399	2%	32%	74%	47

Influenza Outbreak Surveillance

In week 46, seven new laboratory-confirmed influenza outbreaks were reported: two in long-term care facilities, and five in other settings. Among those with influenza type/subtype reported, five were associated with influenza A and two with influenza B. In addition, one ILI outbreak was reported in a school.

To date this season, 34 influenza/ILI outbreaks have been reported, of which 11 (32%) occurred in LTC facilities. Among the 27 outbreaks for which the influenza type/subtype was reported, 21 were associated with influenza A (of which 16 were A(H3N2)), five were associated with influenza B, and one was associated with a mix of A(H3N2) and B. The number of outbreaks to date is within the expected range for this time of year.

Figure 5 – Number of new outbreaks of laboratory-confirmed influenza by report week, Canada, 2017-18, weeks 35 to 46



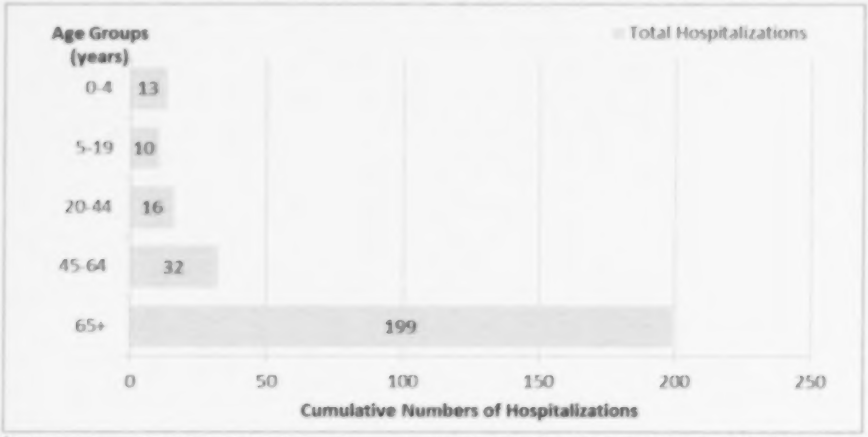
Severe Outcomes Influenza Surveillance

Provincial/Territorial Influenza Hospitalizations and Deaths

In week 46, 19 influenza-associated hospitalizations were reported by participating provinces and territories[1].

To date this season, 270 influenza-associated hospitalizations have been reported, 93% of which were associated with influenza A, and 199 cases (74%) were in adults 65 years of age or older. The number of cases is considerably elevated relative to this period in the previous two seasons. Sixteen ICU admissions and seven deaths have been reported.

Figure 6 - Cumulative numbers of hospitalizations by age-group reported by participating provinces and territories[1], 2017-18 weeks 35-46



[1]Influenza-associated hospitalizations are reported by NL, PE, NS, NB, MB, AB, YT and NT. Only hospitalizations that require intensive medical care are reported by SK.

Pediatric Influenza Hospitalizations and Deaths

In week 46, four laboratory-confirmed influenza-associated pediatric (≤16 years of age) hospitalizations were reported by the Immunization Monitoring Program Active (IMPACT) network. In weeks 45 and 46, the number of weekly hospitalizations is similar to the seven-season average for this week.

To date this season, 25 pediatric hospitalizations have been reported by the IMPACT network, 22 of which were associated with influenza A. Nine ICU admissions and fewer than five deaths have been reported. The number of hospitalizations reported this season has been similar to the same period last year.

Figure 7 - Cumulative numbers of pediatric hospitalizations (≤16 years of age) with influenza by type and age-group reported by the IMPACT network, Canada, 2017-18 weeks 35-46

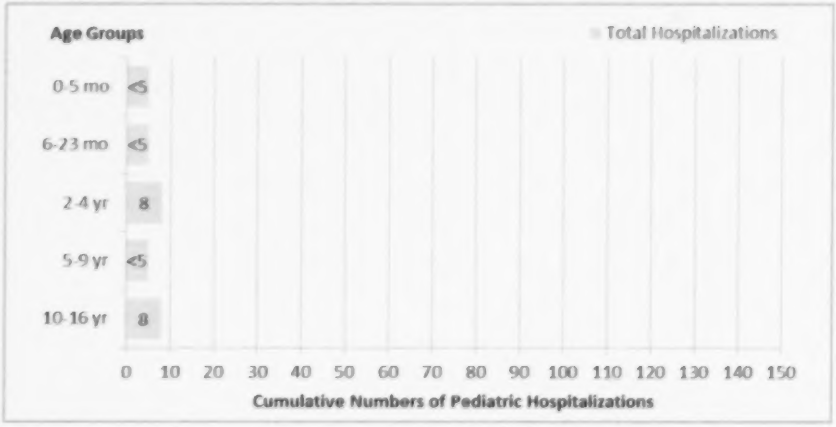
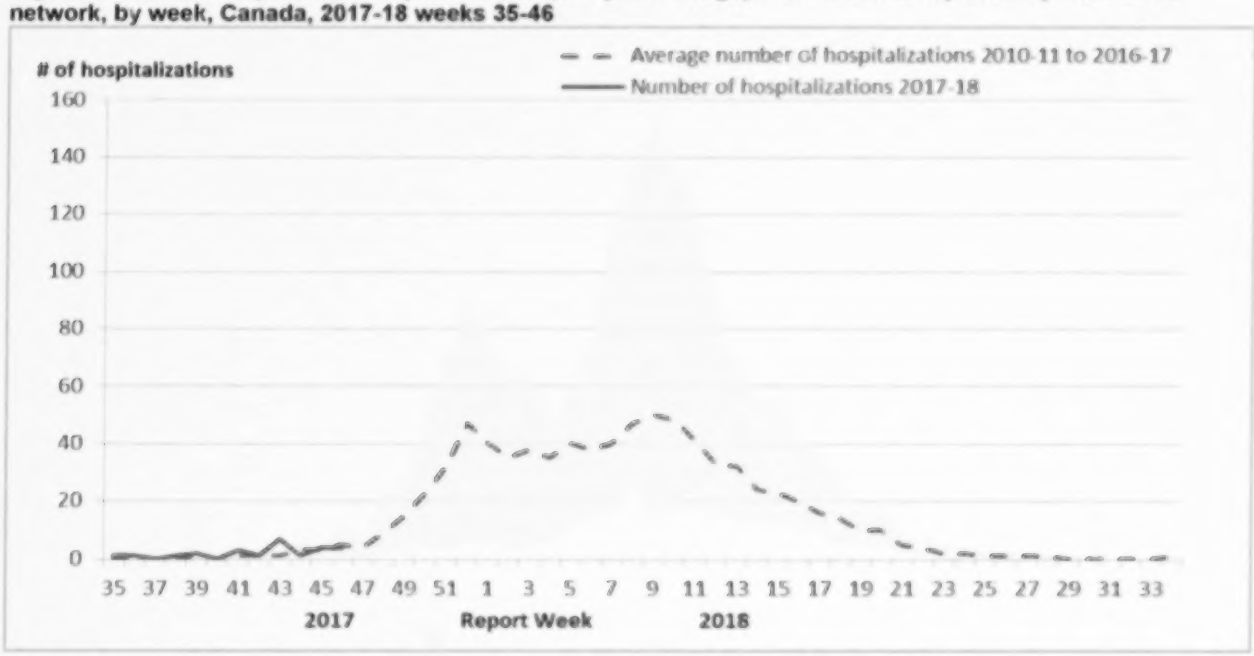


Figure 8 – Number of pediatric hospitalizations (≤16 years of age) with influenza reported by the IMPACT network, by week, Canada, 2017-18 weeks 35-46



The shaded area represents the maximum and minimum number of cases reported by week from seasons 2010-11 to 2015-16

Influenza Strain Characterizations

During the 2017-18 influenza season, the National Microbiology Laboratory (NML) has characterized 88 influenza viruses [70 A(H3N2), 6 A(H1N1)pdm09 and 12 B viruses] that were received from Canadian laboratories.

Antigenic Characterization

Among influenza viruses characterized by hemagglutination inhibition assay during the 2017-18 season, all viruses were antigenically similar to the cell-culture propagated reference strains recommended by WHO.

Table 3 – Influenza antigenic strain characterizations, Canada, 2017-18 weeks 35-46

Strain Characterization Results	Count	Description
Influenza A (H3N2)		
A/Hong Kong/4801/2014-like	9	Viruses antigenically similar to A/Hong Kong/4801/2014, the A(H3N2) component of the 2017-18 Northern Hemisphere's trivalent and quadrivalent vaccine.
Influenza A (H1N1)		
A/Michigan/45/2015-like	6	Viruses antigenically similar to A/Michigan/45/2015, the A(H1N1) component of the 2017-18 Northern Hemisphere's trivalent and quadrivalent influenza vaccine.
Influenza B		
B/Brisbane/60/2008-like (Victoria lineage)	2	Viruses antigenically similar to B/Brisbane/60/2008, the influenza B component of the 2017-18 Northern Hemisphere's **trivalent** and **quadrivalent** influenza vaccine.
B/Phuket/3073/2013-like (Yamagata lineage)	10	Viruses antigenically similar to B/Phuket/3073/2013, the additional influenza B component of the 2017-18 Northern Hemisphere **quadrivalent** influenza vaccine.

Genetic Characterization of A(H3N2) viruses

During the 2017-18 season, 61 A(H3N2) viruses did not grow to sufficient titers for antigenic characterization by HI assay. Therefore, genetic characterization was performed to determine to which genetic group they belong. Sequence analysis showed that 46 A(H3N2) viruses belonged to genetic group 3C.2a and 15 viruses belonged to subclade 3C.2a1.

Additionally, of the nine influenza A(H3N2) viruses that were characterized antigenically as similar to A/Hong Kong/4801/2014, seven belonged to genetic group 3C.2a and two viruses belonged to subclade 3C.2a1.

A/Hong Kong/4801/2014-like virus belongs to genetic group 3C.2a and is the influenza A/H3N2 component of the 2017-18 Northern Hemisphere influenza vaccine.

Antiviral Resistance

During the 2017-18 season, the National Microbiology Laboratory (NML) has tested 97 influenza viruses for resistance to oseltamivir and zanamivir, and all viruses were sensitive (Table 4).

Table 4 – Antiviral resistance by influenza virus type and subtype, Canada, 2017-18 weeks 35-46

Virus type and subtype	Oseltamivir		Zanamivir	
	# tested	# resistant (%)	# tested	# resistant (%)
A (H3N2)	79	0 (0%)	79	0 (0%)
A (H1N1)	6	0 (0%)	6	0 (0%)
B	12	0 (0%)	12	0 (0%)
TOTAL	97	0 (0%)	97	0 (0%)

Note: Since the 2009 pandemic, all circulating influenza A viruses have been resistant to amantadine, and it is therefore not currently recommended for use in the treatment of influenza. During the 2017-18 season, the subset of influenza A viruses that were tested for resistance to amantadine were resistant.

Provincial and International Influenza Reports

- Alberta – Influenza Surveillance Report
- British Columbia – Influenza Surveillance
- Manitoba - Manitoba – Seasonal Influenza Reports
- New Brunswick – Influenza Surveillance Reports
- Newfoundland and Labrador – Surveillance and Disease Reports
- Nova Scotia – Respiratory Watch Report
- Ontario – Respiratory Pathogen Bulletin
- Prince Edward Island – Influenza Summary
- Saskatchewan – Influenza Reports
- Québec – Flash Grippe
- Australia – Influenza Surveillance Report
- European Centre for Disease Prevention and Control – Surveillance reports and disease data on seasonal influenza
- New Zealand – Influenza Weekly Update
- Public Health England – Weekly national flu reports
- Pan-American Health Organization – Influenza Situation Report
- United States Centres for Disease Control and Prevention – Weekly Influenza Surveillance Report
- World Health Organization – Influenza update
- World Health Organization – FluNet

FluWatch Surveillance for the 2017-2018 Season – Notes and Definitions

The FluWatch report is compiled from a number of data sources. Surveillance information contained in this report is a reflection of the surveillance data available to FluWatch at the time of production. Delays in reporting of data may cause data to change retrospectively

Influenza/Influenza-like Illness (ILI) Activity

Influenza/ILI activity levels, as represented on the map, are assigned and reported by Provincial and Territorial Ministries of Health, based on laboratory confirmations, primary care consultations for ILI and reported outbreaks. ILI data may be reported through sentinel physicians, emergency room visits or health line telephone calls, and the determination of an increase is based on the assessment of the provincial/territorial epidemiologist. Maps from previous weeks, including any retrospective updates, are available in the mapping feature found in the Weekly Influenza Reports.

Influenza/ILI Activity Level definitions

1 = No activity: no laboratory-confirmed influenza detections in the reporting week, however, sporadically occurring ILI may be reported

2 = Sporadic: sporadically occurring ILI and lab confirmed influenza detection(s) with **no outbreaks** detected within the influenza surveillance region†

3 = Localized: (1) evidence of increased ILI* ; (2) lab confirmed influenza detection(s); (3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring in **less than 50% of the influenza surveillance region†**

4 = Widespread: (1) evidence of increased ILI*; (2) lab confirmed influenza detection(s);(3) **outbreaks** in schools, hospitals, residential institutions and/or other types of facilities occurring **in greater than or equal to 50% of the influenza surveillance region†**;

* More than just sporadic as determined by the provincial/territorial epidemiologist.

†Influenza surveillance regions within the province or territory as defined by the provincial/territorial epidemiologist

Laboratory-Confirmed Influenza Detections

Provincial, regional and some hospital laboratories report the weekly number of tests and detections of influenza and other respiratory viruses. Provincial public health laboratories submit demographic information for cases of influenza. This case-level data represents a subset of influenza detections reported through aggregate reporting. Specimens from NT, YT, and NU are sent to reference laboratories in the provinces for testing. Cumulative data includes updates to previous weeks. Discrepancies in values in Figures 2 and 3 may be attributable to differing data sources.

Syndromic/Influenza-like Illness Surveillance

FluWatch maintains a network of primary care practitioners who report the weekly proportion of ILI cases seen in their practice. Independent sentinel networks in BC, AB, and SK compile their data for reporting to FluWatch. Not all sentinel physicians report every week.

Definition of Influenza-like-illness (ILI): Acute onset of respiratory illness with fever and cough and with one or more of the following - sore throat, arthralgia, myalgia, or prostration which is likely due to influenza. In children under 5 years of age, gastrointestinal symptoms may also be present. In patients under 5 or 65 years and older, fever may not be prominent.

Influenza Outbreak Surveillance

Outbreaks of influenza or ILI are reported from all provinces and territories, according to the definitions below. However, reporting of outbreaks of influenza/ILI from different types of facilities differs between jurisdictions. All provinces and territories with the exception of NU report influenza outbreaks in long-term care facilities. All provinces and territories with the exception of NU and QC report outbreaks in hospitals.

Outbreak definitions:

Schools: Greater than 10% absenteeism (or absenteeism that is higher (e.g. >5-10%) than expected level as determined by school or public health authority) which is likely due to ILI.

Hospitals and residential institutions: two or more cases of ILI within a seven-day period, including at least one laboratory-confirmed case of influenza. Residential institutions include but are not limited to long-term care facilities (LTCF) and prisons.

Workplace: Greater than 10% absenteeism on any day which is most likely due to ILI.

Other settings: two or more cases of ILI within a seven-day period, including at least one laboratory-confirmed case of influenza; i.e. closed communities.

Serious Outcome Influenza Surveillance

Provincial/Territorial Influenza Hospitalizations and Deaths

Influenza-associated hospitalizations and deaths are reported by 8 Provincial and Territorial Ministries of Health (excluding BC, NU, ON and QC). The hospitalization or death does not have to be attributable to influenza, a positive laboratory test is sufficient for reporting. Only hospitalizations that require intensive medical care are reported by SK.

Due to changes in participating provinces and territories, comparisons to previous years should be done with caution.

Pediatric Influenza Hospitalizations and Deaths

The Immunization Monitoring Program Active (IMPACT) network reports the weekly number of hospitalizations with influenza among children admitted to one of the 12 participating paediatric hospitals in 8 provinces. These represent a subset of all influenza-associated pediatric hospitalizations in Canada.

Influenza Strain Characterizations and Antiviral Resistance

Provincial public health laboratories send a subset of influenza virus isolates to the National Microbiology Laboratory for strain characterization and antiviral resistance. These represent a subset of all influenza detections in Canada and the proportion of isolates of each type and subtype is not necessarily representative of circulating viruses.

Antigenic strain characterization data reflect the results of hemagglutination inhibition (HI) testing compared to the reference influenza strains recommended by WHO. Genetic strain characterization data are based on analysis of the sequence of the viral hemagglutinin (HA) gene.

Antiviral resistance testing is conducted by phenotypic and genotypic methods on influenza virus isolates submitted to the National Microbiology Laboratory. All isolates are tested for oseltamivir and zanamivir and a subset are tested for resistance to amantadine.

Abbreviations: Newfoundland/Labrador (NL), Prince Edward Island (PE), New Brunswick (NB), Nova Scotia (NS), Quebec (QC), Ontario (ON), Manitoba (MB), Saskatchewan (SK), Alberta (AB), British Columbia (BC), Yukon (YT), Northwest Territories (NT), Nunavut (NU).

This report is available on the Government of Canada Influenza webpage.
Ce rapport est disponible dans les deux langues officielles.

We would like to thank all the Fluwatch surveillance partners who are participating in this year's influenza surveillance program.